MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (x) No
Requestor's Name and Address Princeton Pain Management 3710 Rawlins, Ste. 1400 Dallas, TX 75219	MDR Tracking No.: M4-03-7684-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Zurich American Insurance Co. Box 19	Date of Injury: Employer's Name: Insurance Carrier's No.: 2230104586

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		**CPT Code(s) or Description**	**Amount in Dispute**	**Amount Due**
From	**To**			
01/16/03	**01/16/03**	**90801 & 90825**	**$480.00**	**$0.00**

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated 05/30/03 states in part, "…For date of service 01/16/03, we billed the carrier THREE TIMES and NEVER received a response back. A copy of our letters and green cards are enclosed for your review…"

PART IV: RESPONDENT'S POSITION SUMMARY

The carrier representative signed for the requestor's additional information on 7/23/03; the carrier submitted their response on 08/06/03, per Rule 133.307(i) the response is considered untimely and will not be considered.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- CPT Code 90801 and CPT Code 90825 for date of service 01/16/03. Neither party submitted EOB's. Per Rule 133.307(e)(2)(B) the requestor submitted convincing evidence of carrier receipt of the provider request for an EOB. Per the 1996 Medical Fee Guideline, Medicine Ground Rule CPT descriptor these codes are considered timed codes. Review of the submitted report reveals the requestor did not document the amount of time spent in screening the injured worker or in preparing the report. Reimbursement is not recommended.

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to reimbursement.

Ordered by:

Authorized Signature	Typed Name	Date of Order
	Marguerite Foster	01-28-05

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____